
POSITION STATEMENT

Statement of the American Orthopsychiatric Association on the work of the Joint Commission on the Mental Health of Children

CHARACTER OF THE PROBLEM

There is no field of human welfare in which there exists such an enormous gap between recommendation and action as in the field of services to children. The situation would be almost ludicrous, if were not so blatantly tragic. Since 1909, a series of increasingly comprehensive and thoughtful conferences have been held, under the aegis of the President of the United States and with the support of Congress, to examine the needs of the nation's children and to recommend corrective action.¹ Each successive conference has brought together larger numbers of lay and professional people concerned with the welfare of children, has been buttressed by increasingly impressive statistical and research findings, has concerned itself with a wider array of problems, and has made many quite fundamental recommendations for legislative and social action. Each successive conference has been held in an atmosphere of urgency, has called attention to the inadequacy of available services,

and has affirmed that the problems of concern are becoming more, rather than less, grave. Even a cursory examination of the Conference Proceedings indicates that many of the same problems tend to recur from conference to conference, and that many basic recommendations are successively repeated, either because they have never adequately been implemented or because the problems have apparently worsened in the intervening years. This is not to say that nothing has been accomplished. A large body of legislation has entered our statute books at both state and federal levels, public and private agencies have come into being, a substantial amount of research has accumulated, relatively large sums of money have been spent. Yet almost all contemporary experts agree that we are at least as far as we ever have been from the goal of providing adequately for the health, welfare and education of large sectors of our nation's children.

The immediate occasion for this Statement is to express the great desire of the membership of the American

Prepared by the AOA Liaison Committee to the Joint Commission on Mental Health of Children.

¹ The White House Conferences on Children and Youth: 1909, 1919, 1930, 1940, 1950, 1960.

Orthopsychiatric Association that the Joint Commission on the Mental Health of Children should not follow the ineffective path of previous conferences. In making the present Statement, the American Orthopsychiatric Association is fully aware that it cannot hope to supplement the fact-gathering activities of the Ribicoff Commission. Similarly, there is no intention to suggest service innovations or to dilate on what we believe to be the most effective service patterns. As individuals, many members of the Association are making available to the Commission their knowledge and expertise and we expect that the final product of the Commission's work will show the effects of these efforts. The purpose of the present Statement is to give our point of view concerning the reasons for the enormous gap which exists between promise and accomplishment in this field and to urge certain steps which should narrow the discrepancy.

SOCIAL SETTING OF CHILD WELFARE IN THE UNITED STATES

Everything appears to point to the fact that the problems of adequate care for children in our country are deeply enmeshed with a whole variety of major social and economic issues. In starting with this proposition, we are not denying that there are not purely professional problems as well. There is ample room for improvement in the present quality of available services and in the manner in which they are organized. We are confident that the Joint Commission will have many valuable suggestions relating to the improvement of the quality of service, and we can safely leave this task to them. But we believe that the basic lacks in the field of child care

are not as attributable to deficiencies in professional expertise as they are to certain very powerful socio-cultural traditions and to the consequences of large-scale economic change. Unless we squarely face up to the latter issues, no amount of tinkering with the quality and patterning of services will have any significant effect.

On the side of tradition, there are two extremely strong conceptions concerning welfare of our citizens which will need to be drastically altered if any real progress is to be made. The first of these traditions concerns our views of the role of the nuclear family; the second concerns our views of our entire socioeconomic order. With regard to the family, the traditional view is that the primary responsibility for the health and welfare of children rests with the parents. If a child is ill, it is up to the parents to decide on remedies. The state will intervene only in cases of extreme family disorganization, or where obvious crimes against children by their parents are forcibly brought to its attention. Behind this tradition is the implicit assumption that the problems of children can be solved, providing that parents have the *will* to solve them. Whatever was the case in the past, this assumption no longer holds for the parents of some 25% of the nation's children. We will simply have to change our ground-rules so that the society at large is ready to take far more direct responsibility for child care than has hitherto been the case.

The second tradition arises from our course of development into the most affluent country in the world. We have been so bemused by our enormous achievements in both technical and scientific progress that it is particularly

easy to forget that the distribution of these benefits remains quite uneven. Harrington and others have called our attention to the persistence of pockets of poverty, which reflect the fact that large sectors of our population remain outside of the mainstream of economic development. We have been the beneficiaries, during the past two or three decades, of what amounts to a revolution in the techniques of agriculture, but one of its byproducts has been the dumping into our city slums of millions of the displaced rural poor. Similarly, we have been the beneficiaries of vast improvements in industrial technology, but one of its byproducts has been a sharp decrease in the numbers of unskilled and slightly skilled jobs. All of these dislocations are exacerbated by the fact that the bulk of the urban poor are Negroes, or other minority groupings, who are doubly disadvantaged by a long history of discrimination in education and employment. It is to our credit that we have begun to recognize the gravity of these side effects of our industrial progress, as witnessed by our industrial progress, as witnessed by our formal declaration of a "war on poverty." But, again, no amount of reformation of the quality and patterning of our services to children can have much of an impact upon the problem unless truly extraordinary changes take place in our perception of the new urban poor. The content of the American tradition has been that wealth trickles down and that eventually everyone is better off. We are now faced with the danger of a split into two Americas, one portion giving its children the best medical and welfare services in the world, while the other portion can give its children little or nothing.

What all this boils down to is that

we need to bring about drastic changes in our conceptions of the primacy of the family and the dynamics of affluence, if we are to make any headway. Beyond these changes in outlook, we need to be aware that modern society—especially in the great urban centers—has become too complex, too divided within itself, to permit easy utilization of services to children, even if they are greatly increased in quantity. This means that services may have to be restructured, as well as brought to the needy family, rather than simply made available. The huge concentrations of the urban and rural poor tend to be sealed off from sheer physical communication with the service-giving agencies, as well as by the barriers of ignorance and lack of information. The health and service professions have almost entirely abandoned the practice of home-visiting, in face of what appears to be greater and greater need for it. Thus, any proposals for the reform of services to children must include careful consideration of how these proposed new services are to be actually delivered to those who stand in the greatest need for them. It is recognized that to restructure the delivery of services implies a restructuring and integration of the organization of health, education, and welfare programs at Federal, state, and local levels.

SPECIFIC PROBLEMS

In this brief Statement, we cannot hope to provide appropriate documentation for our general position. Such a task must be left to the Joint Commission. We wish, however, to comment briefly on three major problem areas, in which the gap between recommendation and accomplishment is particularly glaring.

1. *Aid to Dependent Children.* As early as the 1919 White House Conference, it was declared that the state and Federal governments must assume the responsibility of supplementing family incomes whenever they were too low to provide adequate care for children. The 1930 White House Conference went further and declared it to be a matter of right for every child to grow up in a family with an adequate standard of living. The 1940 and 1950 Conferences took pains to spell out what was meant by this right, calling for removal of restrictive legislation, eligibility requirements, rigid limitations on the amount of grants, the provision of ameliorative and rehabilitative services, and the like. In the face of these demands, we appear to be moving backward, not forward, as witnessed by the recent cruelly restrictive amendments to the Social Security Act concerning aid to dependent children.

Cloward has established that the current total of over 4 millions of children living in families on public welfare might be trebled if harshly restrictive regulations were abolished.² The authoritative Greenleigh study of aid to dependent children in Chicago³ has provided a gruesome picture of the level of marginal subsistence at which dependent children are maintained, and has amply documented the many medical, dental and psychiatric problems which remain almost wholly neglected. It seems obvious that the levels of support we have niggardly supplied can only serve to exacerbate the problems of children in successive generations.

2. *Prenatal and Postnatal Care.* One of the most sensitive and hotly debated current issues has to do with the relatively high rate of infant mortality in the contemporary United States. We can justifiably boast of the highest level of scientific medicine in the world, but we lag behind a dozen countries in our provisions for prenatal and postnatal medical care. The facts point to an extremely uneven distribution of medical services to prospective mothers, with large sectors of the population (principally the rural and urban poor) having almost no prenatal service at all. This serious maldistribution is emphasized by the fact that the mortality rates for non-whites in the United States is almost exactly twice as high as that for the white majority. (41 deaths per 100,000 live non-white births, as compared to 22 per 100,000 white births—1964 figures). Comparable high rates have been reported for similar *sequelae* of inadequate maternal care.

Again, it is necessary to point out that a series of White House Conferences have written the most detailed prescriptions for prenatal and postnatal care, almost none of which have been as yet implemented in practice. The 1919 White House Conference lists a number of *minimum* requirements (initial medical examination as soon after pregnancy as possible; monthly, and then twice-monthly visits to clinics; periodic laboratory tests; home-visit service by public health nurses, etc.) and successive Conferences have greatly elaborated on these basic needs. Yet it was authoritatively stated in 1946⁴

² Cloward and Piven, *New Republic*, August 5, 1967.

³ Greenleigh Associates, Inc. *Facts, Fallacies and Future: A Study of the Aid to Dependent Children Program of Cook County, Illinois*. New York: Greenleigh Associates, Inc., 1960.

⁴ Arthur J. Lesser, M.D. (Deputy Chief, U.S. Children's Bureau), in *Mothers-at-Risk: The*

that one-third to one-half of mothers in low-income families "are giving birth after having had little or no prenatal care." In enlarging upon the reasons for these phenomena, experts have stressed a trend toward centralization of care, fewer facilities, restrictive eligibility requirements, the lack of provision for night clinics, and the enormous current overcrowding of tax-supported hospitals and clinics.⁵ It is clear that we have not faced up to the consequences of the enormous relative increase in the proportions of low-income families (chiefly Negro and Puerto Rican immigrants) in our cities. There can be little doubt also that poverty is not only a killer of babies, but endows many survivors with a wide range of congenital defects and insufficiencies, which could be avoided or greatly minimized by elementary maternal care.

It must be indicated that mere availability of physicians and clinics for examination and advice, even when obtainable, is only the bare beginning of adequate prenatal care. The high level of nutritional intake, particularly protein and vitamins, avoidance of stress and heavy work and other ingredients of any good program illuminate the intimate relationship between economic variables and health care. Advice without the necessary nutritional and income supplementation for those requiring it borders upon the ridiculous and could be termed little more than a parody upon decent medical care.

3. *Child Health.* It would be gratuitous to recall the many recommendations of

the White House Conferences concerning health service to children, if it were not for the fact that we have hardly begun their implementation. Again, the problem is poverty, not the technical level of professional expertise. The children of the poor tend to disappear from sight once they are born, and are rarely seen by a physician except in cases of the most extreme gravity. Two recent studies suggest how grave and widespread these problems may be.

Under the auspices of Friendly Town, an inner-city Protestant parish in Cleveland, 932 children were given intensive medical examinations on a single day, through the cooperation of the University Hospital. Most of the children came from families who were on public relief, most were Negro children. A few figures from this one-day survey are significant. Of the 932 children, 111 were seriously underweight, 587 needed dental referrals, 150 had serious, but correctible, vision or hearing problems, 26 had severe neurological or endocrinological anomalies.⁶ Not only were these findings considered appalling by the examining physicians, who had all volunteered their diagnostic services, but it was found to be impossible to procure the needed corrective services, after elaborate attempts were made to follow through upon referrals.

In a second study, carried through in Boston on 1,414 children, aged 4 to 6, and enrolled in an OEO Head Start Project in 1965, comprehensive diagnostic work-ups in 5 of Boston's teaching hospitals disclosed that 31% ex-

Role of Social Work in Prevention of Morbidity in Infants of Socially Disadvantaged Mothers. New York: Adelphi University, 1966.

⁵ Monahan and Spencer, Deterrents to prenatal care. *Children*, the U.S. Children's Bureau, Department of Health, Education and Welfare, May-June, 1962.

⁶ Data taken from a description of this study in *Grass Roots*, published by the Inner City Protestant Parish, 13037 Euclid Avenue, Cleveland, Ohio 44112 (Winter, 1967).

hibited major physical defects or emotional problems of clinical significance. The brief report of this study⁷ declares that "most striking of all was the high rate of emotional disturbance. Nearly 25% of all the children had some sort of psychological difficulty, ranging from serious behavior problems to psychoses." The same report states that 28% of Job Corps applicants in Boston had substantial physical defects, "many of which were never diagnosed before."

While the two cited studies are suggestive, they may underestimate the actual magnitude of the problem. Adequate sampling techniques were not utilized and there is no evidence that case-finding techniques were sufficiently exhaustive. At the same time, they give us something of a glimpse of hitherto unexamined and undiagnosed children. It cannot be an exaggeration to affirm that the children of the poor in the contemporary United States appear to do without even the most routine medical and psychiatric service. That up to 15-20% of the nation's children (this is the figure usually given for the proportion of families defined as "poor") may be plagued by untreated physical and emotional problems, appears to be a fairly safe conclusion.

EDUCATION

The entire role of the school as part of the community is focal to the needs of children and their families and must be re-appraised and made suitable for current and ever-changing needs. Changes must be in the direction of fitting programs, methods, materials and curriculum to the goals and problems of a variety of differences in geographical

areas, economic structures, intellectual, and social potential.

Education and the schools as its instrument must be viewed not separate from health and welfare agencies but as an integral part of general development from pre-school to adulthood. Community goals must respect the child's potential in the light of his current ability, his cultural values and attitudes and in the role that he can play in society. Therefore, radical changes must be made in training teachers, administrators and boards of education to see the school life of a child as an aspect of social, physical, emotional and intellectual growth, and not, as has been the case, as a system filling a social structure long outworn and no longer existent. School staff, buildings and facilities should be looked upon as part of community services to the child. The situation now is that the school has been beset with pressures to superimpose these services artificially. To achieve this integration means revolutionary changes in the training of teachers, administration and special services in the colleges of education, in-service training and in the schools as they are run. Consequently the status of educators would be raised. Funds allocated for education should be increased as the needs become clear. Educators must be included in all planning for children in the community and the school viewed as a center for reaching parents and children in relation to all health services.

CONCLUSIONS

The overall conclusion to which we are driven is that the basic barriers to the improvement of child care are *social*

⁷ *Medical World News*, November 5, 1965.

and *economic*, rather than professional or scientific. This does not mean that we are content with the present level of service quality. But the sad fact is that 15–20% of our nation's children (the children of those families defined as "poor") are receiving almost no services at all, whatever we think of its quality. The parents of these children cannot pay for the needed services, have greatly reduced mobility in gaining physical access to the centers which make them available, and may even be largely unaware of the need. In a very real sense, we must establish an entirely new system of health and welfare services, which is carefully adjusted to the ecology of poverty.

We feel very strongly that no real progress will be made even if the available quantity of services is greatly expanded, unless a radical break is made with traditional ways in which services are organized and *delivered*. The health professional cannot expect that the new urban poor will come to him, even if the services he is to provide are without cost to the client. Ignorance of the need for many kinds of service is too widespread, physical and social mobility too limited. The child treatment centers of the future will have to be located and oriented to the population they serve. For older children, it seems logical to integrate the needed services within the public schools.

Finally, we must squarely face the fact that the main danger to the nation's children is the fantastic network of eligibility requirements and restrictive limitations which enmeshes public welfare in the United States. Either we permit a fifth of the nation's children to go down the drain—with all that this implies for public disorder and in-

tolerable inhumanity—or we decide, once and for all, that the needs of children have first priority on the nation's resources.

RECOMMENDATIONS

1. A determined coordinated attack must be made on the fragmentation of power, and responsibility between local, state and Federal levels of governmental authority. Services must be oriented to serve specific populations, within the context of local needs, but guided by strong definite national standards with mechanisms for implementation from Federal funds and supervision.

2. At this time in the history of health care, discontinuities and isolation of services cause major dislocations in provision of care. Integration of personnel and facilities may eventually call for a National Health Service as the only efficient fashion of distributing care adequately.

3. To avoid the present dilemma of perpetuation of the poverty culture, the level of life of all families must be fixed above mere subsistence. Recent governmental reports indicate that a moderate level for a family of four requires a mean of \$10,000 a year. Such an income should be guaranteed each family with increases or decreases in accordance with family size. This level should be maintained in accordance with prices and should be increased as the standard of living rises.

4. The level of income is not the only social problem in the securing of services. The system of delivery of services should include an educational program whereby attitudes and values of recipients and program personnel are altered so that services are offered respectfully and accepted similarly.

5. The major social institutions will require radical increases in budget. For instance, education will need doubling and even tripling in expenditures to reach the adequacy of status this area requires for achieving its goals.

6. We must overcome the fragmentation and discontinuities in the major areas of services to children in education, health and community services. There should be an integrated organizational structure which is responsible for all

services to children and their families.

7. Ultimately the programs discussed above can be achieved only by a basic reallocation of our resources in terms of personnel, industrial production and funds to meet human needs in our changing society.

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